Toward An Exit Visa—Regulating Health Care Decision-Making

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Societies around the world continue to grapple with the problems of making choices about health care, including choices for people who cannot choose for themselves. As the world population continues to age, the number of persons who become mentally incapacitated before they die will increase. As a popular retirement location, Hawaii will not be immune to this worldwide phenomenon. In spite of educational efforts, legislative and regulatory activity, it is not uncommon to find many individuals still have not made any provisions for the care or for the protection of their own persons.

Legislation that would statutorily recognize surrogate (commonly called "family consent" or "default") health-care decision-making was considered by the Hawaii state legislature in its 1995 session.[1] Surrogate decision-making statutes have been enacted in at least 24 states and the District of Columbia.[2] Generally, surrogate decision-making statutes designate which persons are empowered to make health care decisions on behalf of an individual who has not already made any advance decisions and who is no longer considered capable of making decisions for himself or herself. One of the stated purposes of the proposed legislation is to assure that an individual's autonomy and rights under state law are protected.

As in other states, Hawaii's health care decision-making legislation has developed in fits and starts, usually in reaction to troublesome situations. As a result, we now have a somewhat fragmented, incomplete, and sometimes inconsistent set of rules that attempt to address how decisions are made for individuals who are either no longer able to make decisions for themselves or who are perceived to be unable to make decisions.

Doctors, other health care professionals, and lawyers often encounter patients or clients with varying levels of mental capabilities. Under most circumstances, of course, the client or patient can be assisted without the need for legal intervention. Many clients are fully able to make decisions for themselves. Others may appear to be questionably, partially or only intermittently, able to make or communicate decisions. A few will be totally unable to make or communicate decisions. Still others will not want to make a decision or would want somebody else to decide for them.

Increasingly, in the realm of decision-making, the fields of law and medicine intersect. Lawyers are seen serving clients in hospital and nursing home settings. Doctors are asked to provide opinions about the mental capacity of individuals who are being asked to sign legal documents. Lawyers are asked to participate in hospital ethics committee deliberations. Doctors are asked to provide testimony in guardianship actions. Medical students have a legal component to their studies. Law students have an opportunity to study health-care law.[3] Some individuals are both doctors and lawyers. Others find themselves weaving in and out of the two worlds, often by chance. Ethicists, nurses, paralegals, and social workers often form the link between law and medicine. In this aging world, doctors and lawyers are working closer than ever in facing incapacity issues, often with the same patient or client.

Incompetency or Incapacity

In working with patients or clients the question often arises as to whether the individual has "competency" or the "capacity" to make decisions. Distinguishing the ostensibly comparable concepts of (in)competency and (in)capacity may be of some assistance in differentiating these terms. Initially it is important to recognize that adults are presumed to be competent and to have the capacity to make decisions although this presumption is rebuttable.

The concept of incompetency is generally considered to be a legal status imposed by courts. Judicial findings of incompetency are infrequent. When judicial involvement is considered necessary, it is most often in the context of determining whether the appointment of a guardian or commitment to a mental health institution is appropriate.[4] Following presentation of evidence in a hearing, a judge may find an individual to be legally incompetent and appoint a guardian to make decisions on behalf of the "ward" or "protected person" or, if applicable, subject an individual to involuntary mental health treatment. The evidence usually includes the testimony of a psychiatrist or other medical authority skilled in the field of the purported disability of the subject of the proceeding.

The concept of capacity (and incapacity) is more related to specific activities and the determination of decisional capacity is considered to be within the domain of the medical profession. Decisional capacity is usually considered to be present when an individual is sufficiently able (capacitated) to make a particular decision if, minimally, he or she has the ability to understand the nature of the problem or activity he or she is facing, to understand available alternative courses of action (including no action), to understand the possible risks and benefits attaching to each of these alternatives, and is able to express a choice. Each specific activity which involves a decision, such as provision of informed consent for medical treatment, execution of a will, trust, living will, or power of attorney may have a different

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required level of decisional capacity to be considered "valid." The legal profession is beginning to realize that it must do a better job of addressing current dilemmas concerning decision-making capacity. More attention is being given to looking at a means of using more functional, decision-specific capacity evaluations. As in other professions, this increase in attention has been accelerated in part by the increase of such devastating mental afflictions as Alzheimer's and related diseases.

Since the terms "(in)competency" and "(in)capacity" are still used almost interchangeably, even in statutes, it is useful to look at the context of the situation to determine whether the wording is used as a legal term or as a medical term. Hawaii statutes, as do many other state statutes, generally use the terms "capacity" and "incapacity" when addressing judicial proceedings involving the questions of legal competence. In order to clarify what type of situation is being addressed, it may be best to use the general term (in)capacity and then mentally add modifiers (ie, legal (in)capacity (pertaining to one's legal status) and decisional (in)capacity (pertaining to ones capability to make decisions) as appropriate.

From the outset it should be emphasized that an adjudication of incompetency represents a dramatic intrusion on the basic civil rights of the subject of the proceeding. Since a determination of legal incompetence can have a dramatic and long-lasting effect on a person's life, it was suggested at the July 1988 ABA National Guardianship Symposium that "incapacity should be supported by evidence of functional impairment over time" and that "age, eccentricity, poverty or medical diagnosis alone should not be sufficient to justify a finding of incapacity."[5]

To complicate matters, there are different standards for determining incapacity. The standard to be applied depends on the type of decision or instrument or proceeding involved. For example, although an individual may be determined to be incompetent for the purposes of appointing a guardian for that person, the same individual may be deemed competent to execute a will. Likewise capacity to execute a will may require less "competency" than the power to make a gift or to enter into a contract.

Parens Patriae

There are, of course, legal guidelines to determine legal incapacity. The state, in exercising its *parens patriae* (Latin for "father of the country") powers, has the authority to place limitations on the rights and autonomy of a legally incapacitated person. While there is a presumption of legal capacity, when an individual can no longer make decisions necessary to manage personal affairs or property, someone else may need to be appointed to make those decisions. This is usually accomplished through the guardianship process. In Hawaii, *Hawaii Revised Statutes* Section (§) 551-1 states that "family courts have jurisdiction to appoint guardians of persons and circuit courts have jurisdiction to appoint guardians of the property." [6]

Hawaii law (Hawaii Revised Statute § 560:5-304) provides that the family court may appoint any competent person, whose appointment would be in the best interest to the alleged incapacitated person, as a guardian for the person as requested if it is satisfied that the person for whom a guardian is sought is incapacitated and that the appointment is necessary or desirable as a means of providing continuing care and supervision of the person of the incapacitated person.

There is often a stigma attached to an adjudication of legal incapacity and a concomitant loss of civil rights. Usually the old concepts of a global or a complete approach to a determination of legal incapacity is utilized.[7]

Determining Legal Incapacity

There is no single conclusive test to determine capacity in court but it is usually based on a medical diagnosis and prognosis.

Three main approaches[8] to determining capacity seem to have been developed:

1) The outcome approach—decisions that are inconsistent with the values of the helping professionals are conclusive of the person's incapacity.

2) The status test approach—an individual's capacity is judged by his or her physical or mental status or diagnosis without further inquiry about how the status actually affects the person.

3) The functional approach—focuses on the individual's personal ability to function in decision-making situations. Capacity is determined on a decision-specific basis. Capacity is not treated as an all-or-nothing affair. Partial capacity is not the same as incapacity. Capacity may wax and wane.

In 1982, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research suggested that in making determinations about a patient's competency, a clinical assessment should be made to include an inquiry into the extent to which a patient possesses:

1) a set of values and goals

2) the ability to understand information and to communicate and

3) the ability to reason and to deliberate about his or her choices and their consequences.

No matter what approach is taken in any particular guardianship hearing, the court has the power to appoint a guardian *ad litem* to defend the interests of the person who is the subject of the proceeding.[9]

Capacity Issues Outside of Guardianship

There are yet different standards for determining incapacity outside the guardianship arena. The standard to be applied depends on the type of decision or instrument involved. For example, although an individual may be determined to be legally incapacitated for the purposes of appointing a guardian in a guardianship action, the same individual may be deemed competent to execute a will. Applicable standards and tests for determining capacity historically are well developed, especially in the areas of trusts, wills, advanced medical instructions, and powers of attorney.

Powers of Attorney

A power of attorney is a written instrument through which an individual appoints another person as his or her agent (or attorney-in-fact) and grants that person authority to act on his or her behalf to perform certain acts. Powers of attorney traditionally were the written manifestations of the creation of an agency relationship for financial, business or legal purposes. They continue to play an important role, especially in dealing with financial issues relating to a person's institutionalization and payment for health care. It was only rather recently that this legal tool has been utilized to make health care decisions. This health care aspect of powers of attorney will be discussed in the following section concerning advanced medical instructions

and informed consent. Durable powers of attorney are statutorily recognized by law (in Hawaii Revised Statute §551D). It should be noted that there is no specific requirement under Hawaii law that powers of attorney be accepted by third parties.[10]

Informed Consent and the Patient Self-Determination Act

It is clear that all competent individuals have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, continued, withheld, or withdrawn. The basis for making decisions center around the concept of informed consent and a person's constitutional right to refuse unwanted medical treatment.[11]

Hawaii has adopted a strong public policy in favor of the person's right to accept or refuse treatment. Hawaii law provides that "all competent persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, continued, withheld or withdrawn. The artificial prolongation of life for persons with a terminal condition or a permanent loss of ability to communicate concerning medical treatment decisions, may secure only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the person."[12]

As of December 1, 1991, all states and most health care facilities must comply with new Medicare and Medicaid rules regarding patients' right to control their health care treatment. The amendments are known as the Patient Self-Determination Act (PSDA).[13]

The purpose of the PSDA is to help individuals understand that they have strong rights regarding their medical treatment and to help them exercise those rights if they wish. This law was intended to help avoid problems and litigation over the initiation or continuation of unwanted life-prolonging medical treatment. The PSDA prohibits the health care organization from conditioning the provision of care or otherwise discriminating against patients based on whether or not advance directives have been executed. The PSDA also requires each state to develop a written description of state law regarding advance directives. This description is to be distributed by providers to all adult patients upon admission. In an interesting twist, regulators seem to be using the PSDA to force guardianship on individuals who did not execute any advanced directives.

Living Wills

One of the most widely recognized and utilized written advance directives is the living will, or medical treatment declaration. A person can make a living will declaration directing the provision, continuation, withholding, or withdrawal of life-sustaining procedures in the event that he or she is no longer able to communicate medical treatment decisions.[14]

Living wills do not control all health care decisions but only control decisions related to life sustaining medical treatment upon certification by the attending physician that the patient has suffered a permanent loss of the ability to communicate concerning medical treatment decisions. Living wills, for example, do not normally apply to emergency room situations. They do not apply to consent for ordinary medical treatment decisions. They do not apply to consent to admission to a health care facility. They normally do not affect DNA (do not resuscitate) orders. Many people do not know that a patient who suffers cardiac or respiratory arrest in a hospital will routinely be resuscitated unless there is a written DNR order in the medical record. The DNR order is only an order to forgo the otherwise automatic initiation of cardiopulmonary resuscitation and it does not alter other treatment decisions. Of course, patients should be encouraged and prepared to discuss these matters with a physician and to determine what tools can be utilized to address them.

Of course, it is clear that it is not (yet) always necessary to have a validly executed living in order to make decisions about life-sustaining medical treatment.[15] The question of who decides who makes the decision may not be as clear.

Durable Power of Attorney for Health Care

A Hawaii law enacted in 1992 made changes to Hawaii's Durable Power of Attorney Statute and recognized the right of an individual to appoint an attorney-in-fact or agent to make health care decisions.[16]

If properly drafted, the durable power of attorney for health care also can be quite useful in allowing an attorney-in-fact to talk to the principal's doctors, to have access to medical records and to enforce the principal's decisions through court action if necessary. The durable power of attorney for health care can be included in a living will, or it can be used separately, either alone or in conjunction with a living will.

A competent person who has attained the age of majority may execute a durable power of attorney authorizing an agent to make any lawful health care decisions that could have been made by the principal at the time of election.[17]

At the heart of the new law is the provision that states "a durable power of attorney for health care decisions is presumed not to grant authority to decide that the principal's life should not be prolonged through surgery, resuscitation, life-sustaining medicine or procedures, or the provision of nutrition or hydration unless such authority is explicitly stated."[17] In other words, a person needs to state whether he or she is granting the authority to make such decisions.

There are certain limiting aspects of the new law which doctors should understand,[18] but under appropriate circumstances and if properly drafted, a durable power of attorney for health care can permit a patient to appoint an agent who can make legally recognized (and enforceable) decisions.

Proposed Surrogate Decision-making Legislation

Living Wills and Durable Powers of Attorney for Health Care must be made when individuals still have the capability to understand what they are doing. Unfortunately a large percentage of people who are considered to be unable to make decisions for themselves and who enter a health care facility or otherwise need health care treatment have not provided any such advanced medical instructions.

Historically, health care providers have turned to family members for consent in situations where an individual is no longer able to decide for himself or herself. This traditional approach to caring for one's own family members has been considered to be an accepted community practice in the health care community. Although there is a growing sense that this community practice is no longer legally adequate, there is no

actual legal prohibition against such a practice.

There has been, of course, an increase in federal and state regulation of the health care industry and an increased emphasis on preserving the autonomy of citizens. Further, the phenomenon of the increasing numbers of elderly citizens with chronic conditions, often accompanied an inability to make medical decisions is now forcing the community to reconsider how to make choices in medical decision-making in situations other than life-sustaining or life prolonging.

Federal regulations promulgated by the Health Care Financing Administration for long-term care nursing facilities have been interpreted by regulators as requiring any facility resident determined to be decisionally incapacitated to have his or her rights exercised by a person appointed in accordance with state law to act on a resident's behalf. In cases where a resident has not been adjudicated incompetent by the state court, the regulators go on to indicate any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.[19] Since Hawaii does not have a statute which provides for surrogate decision-making in the absence of prior health care instructions (except for limited purposes under the living will statute), regulators have concluded that this situation may lead to a requirement for guardianship actions in court. Threats of citing facilities for noncompliance are increasing.

Whereas the current health care decision statutes do not, apply to such ordinary health care decisions as treating a cold or admitting a person to a long-term-care facility, Hawaii could end up with a rather peculiar result in the way it treats incapacitated individuals. Under certain circumstances its seems there would be less difficulty withdrawing or withholding life-sustaining medical treatment and permitting an incapacitated person to die than admitting the person to a health care facility or treating him or her. Current interpretations of regulations seem to require commencement of a guardianship action in court when an incapacitated person has neglected to make an advanced medical instruction and needs to be helped. With the time and expense it takes to go to court, it can seem easier to some to do nothing. There are, of course, advantages to considering a legally recognized and an expanded version of the traditional "family consent" practice. Certainly regulators will approve of added legislation to fill the current gap in the decision-making spectrum and health care providers may find some comfort in the protections that traditionally accompany such legislation. As long as a statute provides authority and protection, it may be that regulators and health care providers do not really care about the mechanisms involved in the surrogate decision-making statutes but the way that they are written could have a dramatic effect on the lives (or deaths) of the incapacitated person.

Most surrogate decision-making statutes have a listing of individuals (in a priority ranking) who may be looked to when health care decisions need to be made. This listing (or "hierarchy" of authorized decision-makers) usually gives highest priority to a person's spouse or another person who is most closely related to the individual, usually by blood. The theory is that these surrogates will be in the best position to know what the incapacitated individual would have wanted or what is in their best interest.

There can be distinct disadvantages to these surrogate decision-making laws. One disadvantage is the lack of flexibility involved in creating a hierarchy of decision-makers. Arguably, it is not always the person who is the closest blood relation who is the most appropriate decision-maker. Nontraditional families have the most to fear from a legislativelydetermined order of surrogates since the person who actually has the most significant ties to the individual who lacks capacity may not be included in the statutory scheme. Under a surrogate decision-making law, would a family and doctor somehow bypass a patient who is mentally incapacitated much of the time but may have moments of lucidity? Could a doctor follow directions of a surrogate that are inconsistent with the patient's previous statements? These concerns have been addressed to some degree in later drafts of the proposed legislation presented to the Hawaii state legislature. Safeguards pertaining to these concerns may or may not survive the next legislative process.

Much energy has been expended by many people in attempting to respond to the intimidating actions of the regulators. Perhaps we should be asking whether we really need another law on the books to tell doctors and health care facilities under what conditions they can take care of an individual's health care needs. Perhaps the rules cited by the regulators should be examined in light of the mood in Washington, DC to de-regulate government. It may be time to ask why we are so worried by the regulators and what would they actually do if we did not respond to their citation threats? Would they close down all health care facilities or stop health care providers from admitting or treating patients? Would they force us to flood the courts with guardianship actions?

On the other hand, perhaps the debate over surrogate decision-making will conclude that new laws or regulations are needed. If so, it may be the time to revisit the way we make all health care decisions, including decisions to forgo life-sustaining medical treatment. Rather than continuing in our fragmented, incomplete and frequently inconsistent method of approaching health care decisions, we might consider our predicament in a holistic and common sense manner. Otherwise any new law attempting to rectify this newest crisis may only add to the confusion.

Let us carefully consider these significant matters affecting the way we make choices. Let the choices be ours as a community. If we continue to demonstrate to the regulators that we will react to their every threat, we should not be surprised when they demand more and more governmental and legal involvement in health care decisions. It may not be so far-fetched to hypothesize that, ultimately, the regulators would embrace a requirement for an exit visa, prepared by an attorney and properly executed by a judge, prior to permitting a person to leave this world. If we let this happen, all I can hope is that those who oppose such a requirement be greeted (as expressed in Camus' *Stranger*) with cries of execration!

References and Notes

1. Senate Bill No 570, A Bill For An Act Relating To Health Care Decisions. This bill did not become law but other attempts to enact such legislation will likely be made in future sessions.
2. *Right-to-Die Law Digest.* Choice in Dying, 200 Varick Street, New York, NY 10014; (212) 366-5540.
3. Doctors and lawyers should each have at least some medical-legal reference, such as *Aging and the Law:* Strauss P, Wolf R, Shilling D. Commerce Clearing House: 1990. Health Law: Cases, Materials and Problems. Furrow, Johnson, Jost and Schwartz, published by West Publishing Company, 1993.
4. For an overview of incapacity issues, see for example, Planning for the Elderly or Incapacitated Client by S. Schlesinger and B. Scheiner, Published by Commerce Clearing House, Inc., 1990.
5. For an attorney there are also professional ethical issues to take into consideration in dealing with a questionably capacitated individual. In the Hawaii Rules of Professional Conduct, Rule 1.14 states:
   "(a) When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, mental disability, or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) A lawyer may seek the appointment of a guardian or take other protective action with respect to a client, only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest."

6. A few definitions may be helpful to an understanding of guardianship. Under HRS § 560:5-101: "Guardianship proceeding" is a proceeding to appoint a guardian for the person of an incapacitated person.
   A "protective proceeding" is a proceeding...to determine that a person cannot effectively manage or apply the person's estate to necessary ends, either because the person lacks the ability or is otherwise inconvenienced....
   A "protected person" is a minor or other person for whom a guardian of the property has been appointed or other protective order has been made.
   A "ward" is a person for whom a guardian of the person has been appointed.
7. HRS § 560: 5-304 provides that the court may specify areas in which the ward shall retain the power to make and carry out decisions concerning the ward's person, HRS § 560: 5-312 states that a guardian of the person of an incapacitated person has the same powers, rights and duties respecting the guardian's ward that a parent has respecting the parent's unemancipated minor child...
   For property matters HRS § 560:5-408 (3) provides that the court directly or through a guardian of the property has all the powers over the person's estate and affairs which the person could exercise if present and not under disability, except the power to make a will. Fortunately for the protected person, at least orders under these guardianship of the property proceedings have no effect on the capacity of the protected person. (See HRS § 560:5-408 (5).) Combine these proceedings with guardianship of the person proceedings, however, and many rights are in jeopardy.
8. See, for example, "Determining Competency" in Chapter 11, Health Law: Cases, Materials and Problems by: Furrow, Johnson, Jost and Schwartz, published by West Publishing Company, 1993 or Older Wards and Their Guardians by P. Keith and R. Wacker, Published by Praeger Publishers, 1994.
9. See Hawaii Revised Statute §551-2. In addition, Hawaii Rule of Civil Procedure 17(c) provides that "if the incompetent person is not otherwise represented in an action, the court may exercise this power in the interest of the incompetent person or shall make such other order as it deems proper for the protection of the incompetent person."
10. To be valid, a power of attorney should be executed properly and a person must know: what authority they are giving; to whom they are giving authority; the nature of the document in question. The Restatement 2d of Agency suggests that a person must have capacity before he or she can delegate authority to an agent. See *Restatement 2d of Agency, Section 20* (1958). Creation of a power of attorney requires that the principal be mentally competent at the time of execution. See, for example, *Testa v. Roberts*, 542 N.E.2d 654; 44 Ohio App.3d 161 (1988). In order to determine whether an individual has the requisite mental competency to execute a power of attorney, courts have developed tests for this specific area. In *Testa*, the court stated that the test to determine mental competency to execute a power of attorney is the principal's ability to understand the nature, scope, and extent of business he or she is about to transact. A power of attorney may be terminated under three circumstances: death, incapacity (or disability), or revocation. Death automatically terminates the power of attorney. Unless a power of attorney contains specific language providing that the powers shall continue (or commence) during periods of incapacity, the powers will terminate during such periods and the power of attorney is not considered "durable." However, an agent without notice of a principal's death or disability may still exercise the given authority if acting with good faith and in accordance with the granted authority. See HRS §551D-4(a),(b) and Golleher v. Horton, 715 P.2d 1225 (1985).
11. The State of Hawaii Board of Medical Examiners establishes standards for health care providers to follow in giving information to a patient, or to a patient's guardian if the patient is not competent, to insure that the patient's consent to treatment is an informed consent. The standards can include the substantive content of the information to be given, the manner in which the information is to be given by the health care provider and the manner in which consent is to be given by the patient, or a patient's guardian. These standards are contained within the HRS § 671-3 (Informed consent; board of medical examiners standards) which provides, in part:
    "(a) The board of medical examiners, insofar as practicable, shall establish standards for health care providers to follow in giving information to a patient, or to a patient's guardian if the patient is not competent to give an informed consent. The standards may include the substantive content of the information to be given, the manner in which the information is to be given by the health care provider and the manner in which consent is to be given by the patient or the patient's guardian.
    (b) The standards established by the board of medical examiners include provisions which are designed to reasonably inform a patient, or a patient's guardian of:
    (1) The condition being treated;
    (2) The nature and character of the proposed treatment or surgical procedure;
    (3) The anticipated results;
    (4) The recognized possible alternative forms of treatment, including non-treatment, then the standards shall be admissible as evidence of the standard of care required of the health care providers..."
12. See Hawaii Revised Statute § 327D-1. Note: Under Hawaii Revised Statute § 327F, this right also includes the decision to accept or refuse the administration of psychotropic drugs by a health care provider for a psychotic condition. A person suffering from a psychotic condition, but who is competent and in a state of remission at the time of execution may execute a written declaration directing that medical treatment, including the administration of psychotropic drugs, be provided at a time when the person has lapsed and "lacks sufficient understanding to make or communicate responsible medical treatment decisions."
13. Also known as Public Law 101-508, enacted by Congress and signed by the President as part of the Omnibus Budget Reconciliation Act of 1990. The PSDA applies to all Medicare and Medicaid organizations, and specifically includes hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to do five things:
    (1) Provide written information to patients at the time of admission or initial provision of services concerning patients' rights under state law to make decisions about what medical care they want or do not want, including patients' right to accept or refuse life-sustaining or life-prolonging medical treatment.
    (2) Maintain written policies and procedures regarding advance directives, and provide written information to patients about what those policies are.
    (3) Document in the patients' medical records whether they have executed advance directives.
    (4) Ensure compliance with state law at each health care organization which is subject to the new federal law.
    (5) Provide information for the education of the staff and community on issues concerning advance directives.
14. Hawaii Revised Statute §327D-3 directs that declarations:
    (1) Shall be in writing;
    (2) Shall be signed by the person making the declaration, or by another person in the declarant's presence and at the declarant's direction;
    (3) Shall be dated;
    (4) Shall be signed in the presence of two or more witnesses who:
        (A) Are at least 18 years of age;
        (B) Are not related to the declarant by blood, marriage, or adoption; and
        (C) Are not, at the time that the declaration isexecuted, attending physicians, employ ees of an attending physician, or employees of a health care facility in which the declarant is a patient.
    (5) Shall have all signatures notarized at the same time.
    Hawaii Revised Statute § 327D-2 provides that a living will does not go into effect until a patient is certified "to have a permanent loss of the ability to communicate concerning medical treatment decisions." This refers to a state in which a person is diagnosed by a physician as:
    (1) Being in a persistent vegetative state with no reasonable expectation of regaining consciousness;
    (2) Being in a deep coma with no reasonable expectation of regaining consciousness; or
    (3) Having a permanent loss of the capacity to participate in medical treatment decisions, secondary to severe neurological or brain damage, with no reasonable expectation of regaining this capacity.
15. Hawaii Revised Statute § 327D-21 provides, "In the absence of a declaration, ordinary standards of current medical practice will be followed. Although declarations are desirable, nothing in this chapter shall be construed to require a declaration in order for life-sustaining procedures to be provided, continued, withheld, or withdrawn. If there is no declaration, then a verbal statement or statements if they are consistent made by the patient to either a physician or to the patient's friend or relative, may be considered by the physician in deciding whether the patient would want the physician to withdraw or to withhold life-sustaining procedures. Unambiguous statements by the patient, or reliable reports thereof shall be documented in the patient's medical record."
16. See Hawaii Revised Statute §551D-2.5(a). Concerns over artificially prolonging the dying process and how other health care decisions are made when a person is no longer able to communicate have led many people to appoint an agent ("attorney-in-fact" or "proxy") through such a durable power of attorney for health care. Through the health care power of attorney, the agent is able to carry out specific directives or make health care decisions in the absence of such specific directives. In Justice Sandra Day O'Connor's concurring opinion in *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, she stated that delegating authority to make health care decisions to a family member or friend is becoming a common method of planning for the future.
17. See Hawaii Revised Statute §551D-2.5(a). The requirements for making a durable power of attorney for health care under Hawaii law provide that it:
    (1) Shall be in writing;
    (2) Shall be signed by the principal, or by another person in the principal's presence and at the principal's expressed direction;
    (3) Shall be dated;
    (4) Shall be signed in the presence of two or more witnesses who:
    (a) Are at least 18 years of age
    (b) Are not related to the principal by blood, marriage, adoption; and
    (c) Are not, at the time that the durable power of attorney is executed, attending physicians, employees of the attending physician, or employees of a health care facility in which the principal is a patient; and
    (5) Must have all signatures notarized at the same time.
    At the heart of the new law is the provision which states that "a durable power of attorney for health care decisions is presumed not to grant authority to decide that the principal's life should not be prolonged through surgery, resuscitation, life-sustaining medicine or procedures, or the provision of nutrition or hydration unless such authority is explicitly stated." (See Hawaii Revised Statute § 551D-2.5(c). In other words, a person needs to state whether he or she is granting the authority to make such decisions.
    The new law specifically states that a durable power of attorney for health care decisions is only effective during the period of incapacity of the principal as determined by a licensed physician (see HRS § 551D-2.5(d), and that no person can serve as both the treating physician and attorney-in-fact for any principal for matters relating to health care decisions. (See HRS §551D-2.5(e).
    A durable power of attorney for health care decisions executed prior to the new law that substantially complies with the requirements of the new law, will be considered valid provided that the powers relating to the health care decisions granted in the power of attorney have not been previously revoked by the principal or otherwise terminated. See HRS §551D-2.5(f).
18. For example, the new law specifically states that a durable power of attorney for health care decisions is only effective during the period of incapacity of the principal as determined by a licensed physician (see HRS § 551D-2.5(d), and that no person can serve as both the treating physician and attorney-in-fact for any principal for matters relating to health care decisions. (See HRS §551D-2.5(e). Further, a durable power of attorney for health care decisions executed prior to the new law that substantially complies with the requirements of the new law, will be considered valid provided that the powers relating to the health care decisions granted in the power of attorney have not been previously revoked by the principal or otherwise terminated. (See HRS §551D-2.5(f).
19. Federal "TAG" #154 states "In the case of a resident who has not been judged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law."